INTEGRATIVE MULTITHEORETICAL PSYCHOTHERAPY

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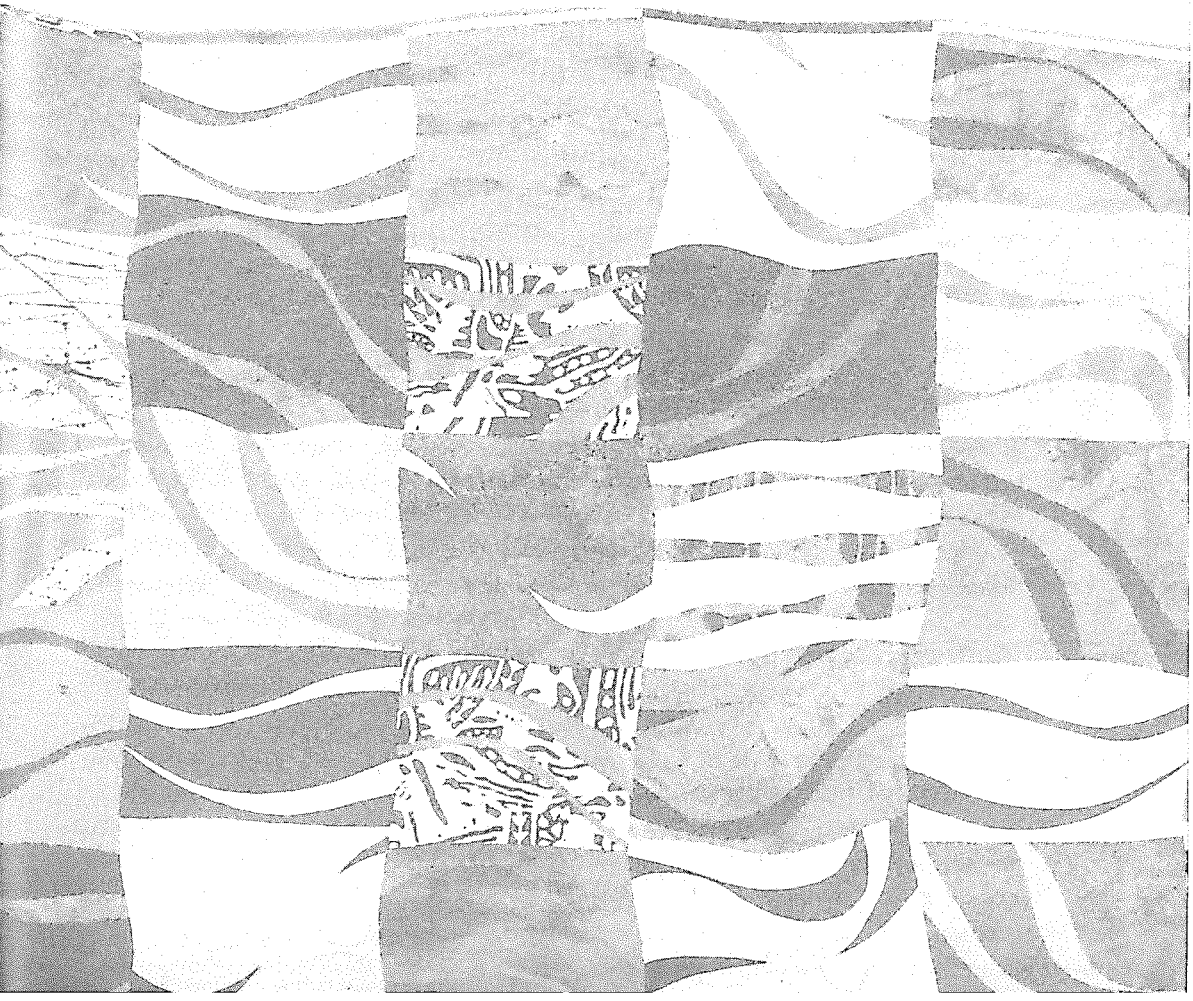
Applications to Treatment and Training



Chapter 11

Multitheoretical Psychotherapy in Action: Case Examples with Four Different Diagnoses

CHAPTER OVERVIEW

Chapter Two identified multitheoretical integration as the third of five principles that characterize *Multitheoretical Psychotherapy* (MTP):

> Integrative psychotherapists utilize diverse theories to understand clients and guide interventions. Multitheoretical conceptualization allows therapists to view theories as complementary vantage points to create a comprehensive formulation. Multitheoretical practice involves combining strategies from different theoretical traditions.

This chapter will focus on multitheoretical integration by describing psychotherapy with four fictitious clients with presenting concerns related to depression, anxiety, substance abuse, and health. These case examples demonstrate the five integrative treatment-planning steps described in Chapter Three and how they can be used to guide psychotherapy. This chapter is designed to show how an integrative psychotherapist can combine ideas and strategies from more than one theory to understand clients and help them achieve multidimensional change. The four clients used in these case examples are summarized in Table 11.1.

Dr. Zoë Pappas (Dr. P.), a fictitious psychotherapist, has been used to illustrate how an integrative psychotherapist can provide multitheoretical psychotherapy for clients with a variety of presenting concerns, combining theoretical approaches and intervention strategies based on the individual needs of clients. Dr. P. provided psychotherapy for each of the four clients described in this chapter using the strategies described in Part Two of the book. She is a Greek-American female in her late thirties. She was born in Athens, and her family immigrated to the United States when she was in elementary school. In graduate school, Zoë took classes in cognitive-behavioral,

TABLE 11.1 Case Example Summaries

MTP for Depression		
Claire	*Diagnosis*	*Focal Dimensions*
A Japanese-American female in her early fifties. She has never been married and was the primary caretaker for her elderly mother who died about one year ago. Claire has felt hopeless and depressed since her mother's death.	Major Depressive Disorder, Single Episode (DSM-IV Axis I: 296.2) Bereavement (DSM-IV Axis I: V62.82)	Thoughts, Feelings, and Interpersonal Patterns
MTP for Anxiety		
Benicio	*Diagnosis*	*Focal Dimensions*
A Mexican-American male in his early twenties. Ben recently graduated from college and moved back in with his parents while he completes an unpaid internship. Ben is gay but is hiding his sexual orientation from his family because of their conservative values.	Generalized Anxiety Disorder (DSM-IV Axis I: 300.02)	Feelings, Actions, and Social Systems
MTP for Substance Abuse		
Dana	*Diagnosis*	*Focal Dimensions*
A Euro-American female in her mid-thirties. She is divorced and has a long-term substance abuse problem. Dana grew up in a poor family from a small rural town. Her father was an alcoholic, and her mother was codependent. They divorced when she was in high school.	Alcohol Dependence (DSM-IV Axis I: 303.90)	Actions, Biology, Social Systems, and Cultural Contexts
MTP for Health Behaviors		
Abe	*Diagnosis*	*Focal Dimensions*
An African American male in his mid-forties. Abe is married with two children. He works as an attorney and describes himself as a workaholic. He recently had his first heart attack after being diagnosed with high blood pressure several years ago. Abe needs to change his health practices in order to preserve his physical health.	Maladaptive health behaviors affecting hypertension (DSM-IV Axis I: 316) Hypertensive heart disease with congestive heart failure (DSM-IV Axis III: 402.90)	Thoughts, Biology, Interpersonal Patterns, and Cultural Contexts

psychodynamic, experiential, and multicultural psychotherapy but never felt sure when to use a particular approach with a specific client. During her last year of classes, one of Zoë's professors offered an advanced seminar in Psychotherapy Integration using Norcross and Goldfried's (1992) *Handbook of Psychotherapy Integration*. During this class, Zoë was drawn to *Multimodal Therapy* (Lazarus, 1992) and the *Transtheoretical Approach* (Prochaska & DiClemente, 1992) as ways to help her decide when to focus on a particular dimension and how diverse theories fit together. As a result of this seminar, Zoë embraced an integrative orientation to psychotherapy and attended the annual conference of the Society for the Exploration of Psychotherapy Integration the following year. After graduate school, Dr. P. committed herself to learning about approaches to psychotherapy that had not been emphasized in her doctoral program. She participated in continuing education programs to learn more about biopsychosocial approaches like *Health Psychology*, as well as systemic and constructivist psychotherapies. In her work, Dr. P. uses an integrative approach and intentionally selects strategies based on the individual needs of her clients. Although Dr. P. enjoys some approaches to psychotherapy more than others, she tries to base her choices on collaborative dialogue with her clients rather than her own personal preferences. The four case studies in this chapter will demonstrate the way that Dr. P. works with different clients based on a multidimensional survey of the presenting concern and using a multitheoretical conceptualization to select interventions from different approaches.

MULTITHEORETICAL PSYCHOTHERAPY FOR DEPRESSION

Client's Presenting Concern

Claire is an Asian-American woman in her early fifties. She has been experiencing feelings of despair as well as physical symptoms of depression since her mother died over a year ago. Claire began attending psychotherapy with Dr. P. after being unable to attend work because of feeling paralyzed and hopeless. Claire described a close relationship with her mother throughout her life. Claire was the oldest daughter in her family and had never married, living with her parents her whole life. Her father had died about ten years earlier, which made Claire and her mother depend on each other even more closely. The year since her mother's death represented the first time that Claire had lived alone. Dr. P. wondered if Claire had been emotionally enmeshed with her mother, but knew that her family role was consistent with cultural expectations for many Asian-American families. Claire reported feeling distant from her younger sisters, although they had tried to reach out and offer support to her. Claire reported friendly relationships at work but did not socialize with

these associates outside of work. Claire had been more distant and moody at work since her mother's death and had recently noticed how it was negatively impacting her ability to succeed at her job.

When Dr. P. first met with Claire she met DSM-IV criteria for Bereavement (Axis I: V62.82; American Psychiatric Association, 1994, p. 684) and a single episode of Major Depressive Disorder (Axis I: 296.2; American Psychiatric Association, 1994, p. 344). Claire's symptoms were clearly tied to the death of a loved one, but her feelings and symptoms had persisted longer and had created more impairment than expected. Therefore, she met diagnostic criteria for a Major Depressive Episode. Claire reported feeling depressed most of the time on most days, she had lost interest in many of the activities she had enjoyed in the past, her appetite had decreased and she had lost weight, she had trouble sleeping most nights, and she felt fatigued much of the time. These symptoms were impairing Claire's ability to succeed at her job.

Watching for Focus Markers

During her first session with Claire, Dr. P listened closely to the way Claire described her experience. In addition to trying to understand what Claire was going through and how she understood her own depression, Dr. P. was watching for focus markers that might suggest focal dimensions that would guide treatment. Many of the focus markers Dr. P. identified were related to Claire's thoughts, feelings, and interpersonal patterns. Related to thoughts, Dr. P. noted that Claire was experiencing pervasive worries, unrealistic expectations, and distorted perceptions. For example, Claire described many negative thoughts about the loss of her elderly mother but could not think of anything positive about the end of her mother's painful illness or any sense of relief from the overwhelming responsibility of caring for her mother while she was dying. Related to Claire's feelings, Dr. P. noticed unexpressed emotions, unrealized goals or dreams, as well as a lack of personal awareness. For example, Claire described caring for her mother in a muted, expressionless manner that made Dr. P. wonder if there were hidden feelings that Claire was not comfortable expressing. Interpersonally, Dr. P. noted focus markers related to repetitive interpersonal patterns, unresolved childhood experiences, and distorted relationships. For example, Claire reported that her sisters have tried to reach out and support her, but she has been unable to accept their support.

Conducting a Multidimensional Survey

At the end of the first session, Dr. P. told Claire that she wanted to spend time during the next session looking at seven dimensions that might be related to her grief and depression. Dr. P. gave Claire a *multidimensional survey* worksheet (based on questions listed in Table 3.4) and asked her to think about

how each of these dimensions might be relevant to her current experience. During the second session, Dr. P. reviewed all seven elements of the multidimensional survey. Here is a summary of the survey:

- *Thoughts:* Claire reported negative thoughts like "I can't go on without my mother" and "It's not worth it."
- *Actions:* Since her mother's death, Claire has been isolating herself from family and friends.
- *Feelings:* Claire reported feelings of despair, hopelessness, and emptiness. When asked about feelings of sadness, Claire reported a numb sense of distance from any sadness.
- *Biology:* Physical symptoms for Claire included decreased appetite and troubled sleeping.
- *Interpersonal:* Claire described a very close relationship with her mother until her death. During her mother's illness, Claire was the primary caretaker.
- *Social:* Claire is the oldest of three sisters. Both of her younger sisters are married with children. Claire's father died about ten years ago. Growing up, Claire always felt closer to her mother than to her sisters or father. She described her father as a good provider who was quiet and emotionally distant.
- *Cultural:* On both sides of Claire's family, her grandparents emigrated from Japan during the first half of the twentieth century. Both parents grew up in the United States but retained important ties to Japanese culture. As the eldest daughter, there was an expectation that Claire would take care of her parents although this expectation was largely unspoken.

Establishing an Interactive Focus

After conducting a multidimensional survey, Dr. P. asked Claire which of these seven dimensions seemed to be most closely related to her grief and depression. Claire felt like her feelings were most distressing. When Dr. P. explored which dimensions might be interacting with Claire's feelings of despair, they identified ways that her thoughts might be interacting with her feelings. They also discussed ways that the close interpersonal bond with her mother was tied to how she was dealing with the loss of that relationship. As a result of this discussion, Dr. P. and Claire agreed to begin psychotherapy by focusing on the interaction between thoughts and feelings within the context of interpersonal patterns. At the end of the second session, Dr. P. asked Claire to keep track of her thoughts and feelings, particularly related to her mother and other interpersonal relationships. To facilitate this process, Dr. P. drew two

columns on a blank piece of paper labeling one column, "thoughts," and the other, "feelings." To demonstrate this way of tracking thoughts and feelings, Dr. P. asked if there had been distressing thoughts or feelings earlier the same day. Claire reported feeling hopeless and thinking that "it's not worth it." Claire agreed to write down her thoughts and feelings when she felt depressed or uncomfortable during the coming week. The interaction worksheet that Claire filled out for Dr. P. is shown in Figure 11.1. At the next session, Dr. P. reviewed this worksheet with Claire. Collecting this kind of data on a day-to-day basis allowed a richer understanding of the interaction between these two dimensions. In later sessions, Dr. P. and Claire expanded their attention to the way that interpersonal patterns shaped both thoughts and feelings.

As an integrative psychotherapist, Dr. P. assumed that Claire's thoughts and feelings were highly interactive. Negative thoughts like "I can't go on without her" seemed likely to result in maladaptive feelings like hopelessness. Conversely, active processing of normal feelings like sadness might result in more accurate thoughts like "the worst of this is behind me." The interaction of thoughts and feelings that resulted in Claire's depression was formed within

Day	Thoughts	Feelings
Monday	It's not worth it.	Hopeless.
Tuesday	I miss my mother.	Lonely.
Wednesday	What do I do next?	Confused.
Thursday	How can I go on?	Exhausted.
Friday	I can't go on.	Hopeless.
Saturday	Why can't I keep going?	Disappointed in self.
Sunday	My sisters seem to be doing so much better.	Ashamed.

FIGURE 11.1 Claire's interaction worksheet allowed her to keep track of her thoughts and feelings.

the critical context of interpersonal relationships and patterns. Claire's feelings of helplessness were part of a pattern in which she learned to cling to her mother rather than reaching out to her sisters, father, or friends outside the family. Although Claire did not choose to focus on actions or biology in psychotherapy, Dr. P. did not ignore these dimensions. Dr. P. observed the way Claire's actions seemed inhibited and almost paralyzed at times. Although Claire told Dr. P. that she did not want to consider antidepressant medication unless her depression got worse, Dr. P. monitored her physical symptoms and encouraged healthy lifestyle choices known to decrease depression. Although Claire and Dr. P. did not focus overtly on social systems and cultural contexts, these dimensions also can be seen as shaping Claire's experience. In her family, Claire had assumed a role in which she created a close bond with her mother that protected her in childhood but left her isolated as an adult. As a Japanese-American, Claire valued family loyalty as part of her Asian heritage. However, growing up in the United States, she was also influenced by American values that made her secretly wish for more freedom and resent some of her family responsibilities. All of these dimensions interacted in a way that influenced Claire's experience and may have contributed to her depression. Attending to the interaction of these dimensions helped Dr. P. understand Claire and guided Dr. P's conceptualization and her choice of intervention strategies.

Formulating a Multitheoretical Conceptualization

Over the next few weeks, after conducting a multidimensional survey, Dr. P. began to think about Claire using psychological constructs drawn from different theories. Because Claire and Dr. P. had agreed to focus on the interaction of thoughts and feelings within the context of interpersonal patterns, Claire was particularly invested in thinking about Claire using cognitive, experiential, and psychodynamic concepts. Over time, Dr. P. was able to construct a multitheoretical conceptualization that included these three theoretical perspectives. Dr. P. viewed these conceptual descriptions of Claire's experience as complementary viewpoints in helping her understand her grief and depression.

Cognitive Conceptualization

From a cognitive perspective, depression is often related to dysfunctional beliefs and a negative bias in processing information: "Depressed patients consistently distort their interpretations of events so that they maintain negative views of themselves, the environment, and the future" (Young, Beck & Weinberger, 1993, p. 241). Cognitive treatment of depression is based on the observation that "when we change depressive cognitions, we simultaneously change the characteristic mood, behavior, and (we presume) biochemistry of depression" (Young, Beck & Weinberger, 1993, p. 241). Using a cognitive model

as part of her multitheoretical conceptualization, Dr. P. hypothesized that global, negative thoughts like "I can't go on without my mother" were contributing to Claire's depression and preventing her from resolving her grief. Although caring for her mother had been overwhelming, Claire could not report any sense of relief. She was not allowing herself to think about things she might want to do with her life now that her family responsibilities had decreased. Dr. P. wondered if Claire might think, at a deep level, that she was not important without her mother. In thinking about Claire using a cognitive perspective, Dr. P. assumed that by helping Claire change her thoughts, the result might be more adaptive feelings, more effective actions, and a decrease in depressive symptoms.

Experiential Conceptualization

Experiential theorists make an important distinction between depression and healthy sadness that occurs in response to loss: "People get sad when they leave or lose the ones they love. Sadness tells them that they will miss their loved ones when they are separated.... Healthy sadness organizes a person to reach out for comfort" (Greenberg, 2002, p. 138). Unfortunately, secondary emotions, like fear or shame, or reactive thoughts, like "I shouldn't feel this way," may interfere with adaptive sadness and grief. Using this conceptual lens, Dr. P. noticed that Claire reported more feelings of hopelessness than feelings of sadness. Claire said that she rarely cried but often felt numb and paralyzed. Dr. P. wondered if the feelings of hopelessness and helplessness were actually blocking the necessary and adaptive experience of sadness that often accompanies grief. Using concepts drawn from *Emotion-Focused Therapy,* Dr. P. concluded that Claire's feelings of hopelessness and paralysis may be secondary emotions blocking the primary adaptive emotion of sadness (Greenberg, 2002). In thinking about Claire using an experiential point of view, Dr. P. thought it would be helpful to assist Claire in exploring her feelings, encouraging more emotional processing, and developing a wider range of emotional expression. She assumed that an adaptive experience of sadness would result in more functional thoughts and more effective actions that might reduce her depression.

Psychodynamic-Interpersonal Conceptualization

From an interpersonal perspective, depression sometimes occurs as a result of complicated bereavement when grief is severe, protracted, and interferes with functioning: "The principle assumption behind the IPT strategy for dealing with abnormal grief is that inadequate grieving can lead to depression.... Depressed patients suffering from complicated bereavement tend to have low self-esteem while often idealizing the lost other or their lost relationship" (Weissman, Markowitz & Klerman, 2000, p. 62). Claire told Dr. P. that she had become paralyzed immediately after her mother's death but had done little

active grieving. Dr. P. also noticed the way Claire idealized her mother and had built her own identity around being "Shizuko's daughter."

From a psychodynamic perspective, psychological problems are often related to maladaptive relational patterns (Luborsky, 1984; Strupp & Binder, 1984). As Dr. P. began to explore Claire's relationship with her mother, Claire talked about a long-term pattern in which Claire wanted to be her mother's favorite and always tried to please her. In response, Claire's mother maintained tight control over Claire, and the two felt a close bond. As a child, Claire cherished this intimate bond with her mother but, later in life, she began to resent the control. However, Claire had never discussed her resentment with anyone and was reluctant to disclose these feelings to a psychotherapist. Dr. P. thought that part of their work in psychotherapy might involve working through thoughts and feelings related to her mother's controlling relationship with Claire and exploring the resentment that Claire had kept buried for so long.

As an integrative psychotherapist, Dr. P. assumed that these conceptualizations were complementary and interactive. The dependent and isolated interpersonal pattern that Claire had enacted with her mother shaped the dysfunctional thoughts and maladaptive feelings that were tied to Claire's depression. The intense relational bond with her mother led her to the conclusion that she couldn't go on alone and left her feeling hopeless. The hidden feelings of resentment led Claire to think of herself negatively in a way that contributed to her depression. Dr. P. used all three conceptual lenses to support a multitheoretical approach to psychotherapy.

Choosing Interventions from a Catalog of Key Strategies

In her ongoing work with Claire, Dr. P. emphasized the use of cognitive, experiential-humanistic, and psychodynamic-interpersonal strategies to help Claire change her thoughts and feelings and to understand the interpersonal pattern that had developed with her mother.

Cognitive Strategies

Dr. P. used cognitive skills to identify thoughts and modify beliefs that might be interfering with normal bereavement and contributing to depression. Dr. P. used a variety of cognitive strategies with Claire including identifying thoughts, challenging irrational thoughts, evaluating evidence, modifying beliefs, and encouraging accurate perceptions. For example, Dr. P. helped Claire develop accurate perceptions about the amount of effort it would take to meet her social needs and identify specific ways she could reach out to others. Initially, Claire reported thoughts like "I'm all alone" and "I can't go on without her." Eventually, she was able to embrace more adaptive thoughts such as, "I'm moving more slowly since my mother's death" and "the worst is

behind me." Chapter Four described in greater detail the way Dr. P. used cognitive strategies to help Claire resolve her grief and decrease her depression.

Experiential-Humanistic Strategies

Experiential interventions were used to explore Claire's feelings and to help her experience and express adaptive emotions. Some of the experiential skills Dr. P. used with Claire included clarifying the impact of feelings, fostering self-actualization, supporting authenticity, focusing attention, and creating experiments. Over the course of psychotherapy, Claire was able to explore paralyzing feelings of helplessness after her mother's death and hidden feelings of resentment about bearing the burden of care for her parents. Claire was able to discover a sense of tension between wanting to express her feelings and an opposing desire to hold them in. As a result of this experiential exploration, Claire was able to feel authentic feelings of sadness allowing her to grieve in a more adaptive manner. These adaptive feelings of grief and sadness had been blocked by a secondary reaction of helplessness and unresolved feelings of resentment. After working through her grief in psychotherapy, Claire felt more freedom to express her authentic self and to embrace her own life in a way that allowed for growth and self-actualization. Chapter Six described Dr. P.'s use of six different experiential-humanistic strategies to help Claire explore and resolve her feelings related to her mother's death.

Psychodynamic-Interpersonal Strategies

Dr. P. used psychodynamic-interpersonal strategies to help her actively deal with grief and to understand interpersonal patterns related to Claire's relationship with her mother. Claire was able to recognize a pattern in which she had bonded with her mother in a way that provided security for her in childhood but later became restrictive. In response to the close relationship with her mother, Claire felt secure as a child but resentful as an adult. Claire felt guilty about her resentment and hid these feelings, even from herself. Some of the skills used to explore interpersonal patterns included interpersonal interpretations, exploring childhood experiences, modifying relational interactions, and adapting to interpersonal losses. When Claire began enacting outdated interpersonal patterns in psychotherapy, Dr. P. was able to help her see what was going on and make changes in the way they interacted in order to break old patterns and make way for interpersonal changes. After understanding the past and making changes in the therapeutic relationship, Claire was more prepared to modify current relationships and create new friendships that did not repeat old patterns. These interpersonal changes allowed Claire to reduce her isolation and to gain social support in ways that helped her resolve her grief and reduce her depression. Chapter Eight described in greater detail the way Dr. P. used psychodynamic-interpersonal strategies to help Claire resolve her grief and decrease her depression.

Although the cognitive, experiential-humanistic, and psychodynamic-interpersonal strategies that Dr. P. used were described in different chapters, this may lead the reader to the false conclusion that these strategies were used in an isolated or sequential manner. The opposite is true; during most sessions, Dr. P. used strategies drawn from at least two or three different theoretical traditions. Dr. P. worked with Claire's thoughts and feelings in an interactive manner, always aware of their interpersonal origin. Dr. P. assumed that functional thoughts like "I want to reach out to others" were associated with adaptive feelings like hope and love. As Dr. P. helped Claire explore an outdated interpersonal pattern, Claire was able to work through painful thoughts and feelings and embrace more adaptive interpersonal responses. Dr. P. also was able to watch the therapeutic relationship and use it as an interpersonal laboratory where patterns could be experienced in the here and now and new thoughts and feelings could be embraced. In an integrative fashion, cognitive, experiential-humanistic, and psychodynamic-interpersonal approaches were used together to help resolve Claire's grief and reduce her depression.

Outcome

As a result of working with Dr. P., Claire reported a reduction in depressive symptoms and experienced greater resolution to her grief. Her thoughts became more functional with fewer negative distortions. Rather than assuming that she could not go on without her mother, she concluded that her life without her mother would be very different and that she was beginning a new chapter in her life. As a result of psychotherapy, Claire's feelings shifted from despair and hopelessness toward a more adaptive sense of sadness and grief that could be resolved over time. Dr. P. helped Claire process her sad feelings in an active way, expressing her grief in words and actions. Eventually, Claire was able to articulate what her mother's death meant to her and could let herself cry at this profound loss. She was able to come to a more balanced view of her mother as a person with both positive and negative traits. Claire was also able to gain a greater understanding of why she had wanted to be her mother's favorite but how this interpersonal pattern created personal restrictions in other areas of Claire's life. When Claire left psychotherapy, she reported that she still felt sad about her mother's death but did not dwell on these thoughts throughout the day. Claire felt like she was ready to move on and to do things for herself that she had been unable to do when her mother was alive.

Future Development of MTP for Depression

In this case example, Dr. P. treated Claire's depression using a multitheoretical approach consistent with the way MTP is described in this text. In the future, it may be useful to develop more formal descriptions of how MTP can be used

to treat specific disorders such as depression, anxiety, or substance abuse. For example, if MTP were applied to depression, it would be helpful to provide a multidimensional description, specifying the ways that depression results in negatively biased thoughts, maladaptive feelings like hopelessness, and a decrease in pleasurable actions. A multidimensional description of depression would also specify ways that depression is related to biology, interpersonal patterns, social systems, and cultural contexts. Conceptual models could be developed corresponding to each of these dimensions, elaborating on the ways that different theories can help a counselor understand a client's depression. Psychotherapists using MTP to treat depression would be encouraged to conduct a multidimensional survey and formulate a multitheoretical conceptualization as part of integrative treatment planning. Finally, intervention strategies could be described that are drawn from different theoretical approaches to the treatment of depression. Emphasis can be placed on describing key strategies that have been established as a part of evidence-based practice.

The application of MTP to depression and other specific disorders could be used to solve a current dilemma in psychotherapy research. In the ongoing process of identifying empirically supported treatments, researchers have already found that some disorders can be treated successfully using a variety of theoretical approaches. For example, cognitive, interpersonal, psychodynamic, and behavioral treatments for depression have already been identified as "well-established" or "probably efficacious" (Chambless et al., 1998). Recent research has demonstrated support for experiential treatment of depression (Greenberg & Watson, 2005). MTP could be used to identify key strategies drawn from these established treatments and to describe methods for integrating these interventions in practice. Future research could investigate whether intervention strategies can be successfully combined in multitheoretical practice and whether this type of integrative treatment leads to better outcomes compared to single-theory treatments.

MULTITHEORETICAL PSYCHOTHERAPY FOR ANXIETY

Client's Presenting Concern

Benicio is a Mexican-American male in his early twenties. Ben graduated from college six months earlier and had to move back into his parents' home while he completed a one-year unpaid internship. Ben sought psychotherapy with Dr. P. to deal with symptoms of anxiety including excessive worries, restlessness, irritability, and sleep disturbance. His anxiety was making it hard to focus on work, and he found himself feeling irritable around his family. During the first session, Ben talked about a long-term struggle with anxiety. Although he did not reveal it at first, Ben is gay and started dating other men in college.

He was hiding his sexual orientation from his parents because of their conservative religious and cultural values. Eventually, after revealing his sexual orientation to Dr. P. in the third session, a more comprehensive history was collected.

At the time of the first session, Ben met DSM-IV criteria for Generalized Anxiety Disorder (Axis I: 300.02; American Psychiatric Association, 1994, p. 436). Ben's anxiety was creating impairment in his social and occupational functioning. At the time he came to see Dr. P., Ben reported anxiety and worry most days and felt unable to control the worry. Ben reported restlessness, difficulty concentrating, irritability, muscle tension, and restless sleep. These symptoms were causing significant distress in social functioning in his family and moderate impairment at work.

Ben told Dr. P. that he had begun to experienced lots of fear and guilt that he might be gay during high school. His Catholic family did not approve of homosexuality and had always wanted Ben to consider the priesthood because of his keen interest in religion. The conflict between his love for the Catholic Church and his growing attraction for men created a great deal of anxiety for Ben. In college, Ben began attending the Newman Center on campus and met liberal Catholics who did not disapprove of gays. He began attending a support group for students who were exploring their sexual orientation. Eventually, Ben became more comfortable with his attraction to men and began dating. Ben reported that his last two years at college were great and he experienced fewer symptoms of anxiety. However, when Ben returned home about six months ago, he began feeling anxious again and dealt with it by isolating himself at home and not talking about his personal life with family members.

Watching for Focus Markers

Many of the focus markers that Dr. P. noted were related to Ben's feelings, actions, and social systems. Related to Ben's feelings, Dr. P. noticed focus markers related to unexpressed emotions, unrealized goals, and a conflicted sense of self. For example, there seemed to be a conflict between how Ben saw himself and how he was seen by others that created fear and anxiety for him. Related to actions, Ben revealed conditioned responses and environmental barriers to expressing himself openly. For example, Ben's anxiety was associated with social situations in which family members asked him personal questions, particularly about relationships. As a result, Ben tried to avoid conversations with relatives at social gatherings and often felt tense around his family. When Dr. P. listened to Ben describe his family, she noted social systems focus markers including unresolved family problems, an inability to connect socially, and a distorted personal narrative. For example, as Ben told his story, it sounded as if he was facing a problem that could never be resolved.

Conducting a Multidimensional Survey

At the end of the first session, Dr. P. gave Ben a multidimensional survey worksheet and asked him to jot down some ideas about how each of seven areas was related to his anxiety. During the second session, Dr. P. asked Ben questions about all seven dimensions, trying to understand Ben's situation in a comprehensive way. Here is a summary:

- *Thoughts:* Ben reported pervasive worries centered around the thought that "my family would reject me if they really knew me."
- *Actions:* Ben's actions revealed a conflict in which he was withdrawn and secretive around his family and outgoing and vivacious around his college friends.
- *Feelings:* Ben had a strong feeling of fear that his family would reject him if they found out a secret he was hiding. His fear was so immediate and intense that he had a hard time knowing whether his fears were realistic or not. Ben also reported feelings of guilt related to disappointing his family and feeling ambivalent about his Catholic faith.
- *Biology:* The anxiety that Ben reported included physical sensations of tension and somatic symptoms including nausea and shakiness.
- *Interpersonal:* Ben reported that he had always wanted to please others and was critical of himself when he was unable to fulfill the expectations of others. Ben reported that this interpersonal pattern originated in the close relationship with his mother when he was growing up.
- *Social:* Ben was the youngest child in a large Mexican-American family. In his family of origin, Ben had always played the role of the good boy who did as he was told. Ben was closer to his mother and reported that his father was not around much as he grew up because he held down two jobs.
- *Cultural:* Ben's cultural identity was rooted in his Mexican heritage and his Catholic religion. As a teenager, Ben didn't feel like he could live up to the cultural expectations associated with machismo and did not always feel comfortable around other teenage boys. On the other hand, when Ben was growing up, he felt a close affinity to his Catholic faith and his mother had hoped that Ben might become a priest.

Establishing an Interactive Focus

After discussing all seven dimensions, Ben said that he felt that his feelings of anxiety, fear, and guilt were the most problematic. When Dr. P. discussed which other dimensions might be most closely related to his feelings, they concluded that his actions related to interacting with his family were closely

related to his emotions and that these actions and feelings were shaped by the social system in which he lived. Therefore, Ben and Dr. P. agreed to focus on three focal dimensions: (1) his feelings of fear and guilt, (2) his actions around social interactions with his family, and (3) the social system in which he lived, including his Catholic family and the broader Mexican-American community.

After agreeing on this focus, Dr. P. asked Ben to begin to monitor the interaction between his actions and feelings in social situations, particularly with his family. To begin this process, Dr. P. asked Ben to recall a recent situation in which he felt anxious with his family. Ben recalled a recent situation in which his mother asked him if there were any nice girls working at his internship site. Ben reported feelings of fear, tension, and a desire to avoid the conversation. Ben's actions included mumbling and changing the subject and then abruptly ending the conversation and leaving the room. Dr. P. wrote these feelings and actions on a two-column sheet of paper and asked Ben to continue to keep track of social interactions in this way.

Dr. P. assumed that the relationship between Ben's feelings, actions, and social system was highly interactive. His perception of family disappointment and his family role of *good boy* or *obedient child* were in conflict. This conflict created feelings of fear and guilt. When these feelings were triggered, Ben withdrew from his family that had once represented a great source of social support. As a result of withdrawing from his family, Ben sought more support from college friends but then felt guilty about avoiding his family and afraid his family might discover his secret. The interaction between these three dimensions created a vicious cycle in which Ben felt trapped and hopeless about ever resolving these conflicts. As mentioned earlier, Ben did not initially disclose his sexual orientation to Dr. P.

Formulating a Multitheoretical Conceptualization

Because Ben and Dr. P. had agreed to focus on feelings and actions within the context of social systems, Dr. P. began to formulate a multitheoretical conceptualization based on ideas from experiential-humanistic, behavioral, and systemic-constructivist theories of psychotherapy. Dr. P. assumed that these different theoretical perspectives would represent complementary viewpoints that would help her work with Ben in a holistic and integrated manner.

Experiential Conceptualization

From the very beginning of their work together, Dr. P. sensed that Ben was afraid to reveal himself to her. Therefore, Dr. P. tried to create a safe environment that would allow Ben to open up and seek help from her. Dr. P.'s unconditional positive regard for Ben allowed him to feel safe enough to reveal his gay sexual orientation to her. Once Ben had overcome his fear of revealing himself to Dr. P., the central role of fear in his current life could be seen more

clearly. Experiential psychotherapists make a distinction between fear in response to external danger and anxiety about perceived threats:

> Fear is . . . generally a transient response to a specific threat that abates after one has escaped the danger. Anxiety, on the other hand, is a response to "threats" sensed in the mind—symbolic, psychological, or social situations rather than an immediately present, physical danger" (Greenberg, 2002, p. 143).

In working with anxiety and fear using an experiential approach, it is often useful to help clients move from a vague sense of anxiety toward a clearer feeling of fear and then evaluate whether a situation represents a real danger and identify an adaptive response to any threats in the environment. Using this conceptual perspective, Dr. P. hypothesized that Ben's anxiety represented an emotional response to the fear that his family would discover that he is gay and reject him. When he began attending psychotherapy, Ben had a hard time identifying his feelings and was more aware of a general sense of tension or uneasiness. At this time it would have been difficult for Ben to identify specific feelings of fear. Dr. P. thought it might be useful to explore Ben's anxiety to see if specific fears about family rejection and loss of support might underlie his vague feelings of anxiety. Dr. P. saw the possible loss of family support as a real danger that should be taken seriously. However, she wanted Ben to become more aware of his feelings before deciding how to respond.

Behavioral Conceptualization

From a behavioral perspective, the excessive worries that typify generalized anxiety disorder can be considered actions that can be targeted for change. When worry behaviors are viewed from an operant conditioning perspective, it can be seen that the corrective, preventive, or ritualistic actions that anxious clients often engage in serve as negative reinforcement for worrying because they often result in temporary reduction in anxious feelings (Brown, O'Leary & Barlow, 1993). In Ben's case, Dr. P. observed worry behaviors that Ben used to prevent his family from finding out he is gay. Some of Ben's worry behaviors included avoiding answering personal questions asked by his family, refusing to give gay friends his home phone number, and not answering cellular phone calls at home. Dr. P. concluded that these worry behaviors might actually be contributing to his anxiety because of their ritualized and compulsive nature. For example, when Ben abruptly ended a conversation with a family member, he felt less anxious and his sense of relief actually reinforced the action. These avoidant behaviors were temporarily alleviating his fears but they were also making it less pleasant to live at home and interact with his family. Dr. P. concluded that it would be useful to help Ben decrease his worry behaviors and that he would benefit from identifying more effective actions to deal with his anxiety.

Systemic-Constructivist Conceptualization

From a systemic perspective, it is important to understand symptoms within their social context. One way to think about the social context of a family is to identify roles or patterns of communication that individuals frequently exhibit within the family system. For example, Virginia Satir (1972) observed that family members under stress frequently resort to one of four patterns of communication called placating, blaming, computing, and distracting. When Dr. P. talked to Ben about his family role growing up, Ben said that he always thought he had to be a *good boy* fulfilling the communication pattern that Satir (1972) referred to as the placater: "The *placater* always talks in an ingratiating way, trying to please, apologizing, never disagreeing, no matter what. He's a 'yes man.' He talks as though he could do nothing for himself; he must always get someone to approve of him" (p. 64). As Dr. P. explored this role, it appeared that in his family, Ben had been successful in fulfilling the good boy role and placating those around him. As the youngest of five children Ben tried not to cause trouble and was always a "little darling." In high school, when Ben began to think he might be gay, Ben concluded that being gay would violate the good boy role, and he concluded that he could not become gay. Attending college in another state allowed Ben to consider his sexual orientation outside the confines of his family system, and he became comfortable with his gay identity. Unfortunately, moving back to his family home after college created tension between his gay sexual orientation and his good boy family role. From a systemic perspective, this tension was an important part of understanding Ben's anxiety. Dr. P. hypothesized that Ben would have to face the possibility of disappointing his family and change long-standing patterns of communication if he was to feel comfortable being gay and being a member of his family system. Therefore, Dr. P. tried to help Ben understand why he chose to enact the good boy role as a child but tried to help Ben consider the possibility that this role was no longer viable or adaptive. Dr. P. tried to encourage Ben to think about balancing his need for individuation and his family's need for stability (Allen, 1993).

Dr. P. assumed that these three conceptualizations could be used in a complementary manner. She assumed that each of these formulations provided a different vantage point from which she could view and understand part of Ben's experience. Dr. P. tried to understand Ben's feelings and actions within their social context. Ben's anxiety and fear were related to the loss of his family role and his inability to rely on well-learned communication patterns. These feelings and social constraints were shaping his avoidant behavior that reinforced his worries. In this way, Dr. P. felt that experiential, systemic-constructivist, and behavioral perspectives could be used together to create a comprehensive and multifaceted formulation that could guide her choice of therapeutic actions. After discussing these interactive perspectives for a few

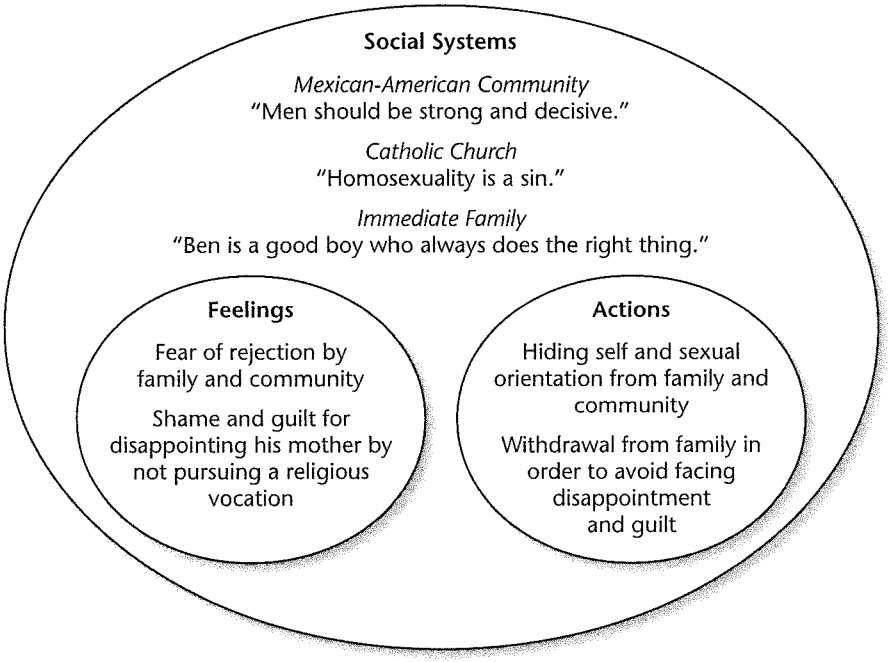


FIGURE 11.2 Ben's interaction diagram highlighted the way that social systems were shaping his feelings and actions.

sessions, Dr. P. and Ben drew an "interaction diagram" that created a visual picture of Ben's conflict. This interaction diagram is illustrated in Figure 11.2.

Choosing Interventions from a Catalog of Key Strategies

Because of the interactive focus on feelings and actions within social systems, Dr. P. chose to emphasize experiential-humanistic, behavioral, and systemic-constructivist interventions.

Experiential-Humanistic Strategies

Dr. P. used experiential-humanistic strategies to help Ben understand his emotional experience from an internal, phenomenological perspective and to learn to respond to his situation with adaptive feelings. First, Dr. P. communicated empathy and unconditional positive regard to create a safe environment in which Ben could disclose his sexual orientation that was at the heart of his family struggle and his feelings of fear and anxiety. Dr. P. also helped Ben identify his feelings and to distinguish between a vague sense of anxiety and a more specific fear of losing his family's love. Some of the other experiential strategies that Dr. P. used with Ben included encouraging the expression of feelings, helping him integrate different parts of himself, and

fostering here-and-now awareness. As a result of increased emotional awareness, Ben became aware of feelings of sadness that were deeper than his fear or guilt. He was also able to begin to embrace a sense of freedom and responsibility that would allow him to make difficult choices in spite of the presence of fearful consequences. Chapter Six provided examples of the experiential strategies that Dr. P. used to help Ben work through difficult feelings and embrace adaptive emotions.

Behavioral Strategies

Dr. P. used behavioral strategies to help Ben identify actions that he wanted to change and to eliminate conditioned responses of anxiety. Some of the behavioral strategies that Dr. P. used with Ben included illuminating patterns of reinforcement, assessing Ben's stage of change, prescribing specific actions, and exposure to images or experiences. For example, Dr. P. used worry exposure to help Ben face imagery related to the worst possible feared outcome (Brown, O'Leary & Barlow, 1993). As a result of these behavioral strategies, Ben was able to decrease his avoidance behaviors, increase social interactions with family members, decrease subjective feelings of anxiety, and prepare for coming out to his family. Chapter Five provided examples describing how Dr. P. used behavioral strategies to help Ben change his actions and decrease his anxiety.

Systemic-Constructivist Strategies

Dr. P. used systemic-constructivist strategies to help Ben understand how his thoughts, actions, and feelings were shaped by his family system. Some of the systemic strategies used included understanding problems within a social context, identifying family roles, and clarifying family belief systems. For example, the description of the family structure resulted in realizing that Ben had created a subsystem with his mother and sisters and that he tended to be somewhat enmeshed with these members of his family whereas he was often disengaged from his father and older brothers. Using a constructivist perspective, Dr. P. tried to help Ben change the way he constructed social meaning by encouraging an adaptive narrative in which Ben could see a new chapter beginning in his life that would be different from previous chapters. As a result of this systemic-constructivist emphasis in psychotherapy, Ben was able to relate to his family in a different way and was able to construct personal meaning in a more active and personal manner. Chapter Nine described the way Dr. P. used systemic and constructivist strategies to help Ben understand and adapt to his family system.

Although the experiential-humanistic, behavioral, and systemic-constructivist strategies were described in different chapters, they were not used in isolation or during different phases of treatment. Dr. P. made a conscious effort to attend to the interaction between feelings, actions, and social systems

throughout psychotherapy. As a result, most sessions included a focus on all three dimensions and utilized strategies from two or three different theoretical approaches. Dr. P. observed that as Ben's fears decreased, he was more able to choose adaptive actions that allowed greater flexibility within his family. Once Ben made active changes in his family, there were shifts in the way the whole system interacted. These changes allowed Ben to construct a new narrative that resulted in different actions and feelings. Ben was able to find ways to balance his need for individuation with his family's need for stability.

Outcome

As a result of psychotherapy, Ben reported decreased feelings of anxiety both inside his family and in other social situations. Ben was able to feel grateful for the family support he had and feel sad about some of the things he still missed. Ben was able to make better choices about what to share and how to interact with different family members. During psychotherapy, Ben was able to come out to his sister, with whom he felt the closest. At the time of termination, Ben was preparing to eventually come out to his mother but was not sure exactly when that would occur. He was able to identify reasons why he did not feel as close to his father and brothers, and was making gradual changes in these relationships, selectively sharing personal information and seeking out comfortable contact at a gradual pace. As Ben became less fearful about his family finding out he was gay, he was able to make new friends in his old home town. He joined a support group for gay Catholics and found ways to integrate his sexual orientation with his spirituality. When he left psychotherapy, Ben reported feeling that his social feelings and actions were more consistent and congruent. Ben said he appreciated the way Dr. P. helped him look deep within himself as well as find ways to express himself with congruent actions across different social situations.

Future Development of MTP for Anxiety

This case example described the way Dr. P. applied a multitheoretical approach to the treatment of Ben's anxiety. In the future, it may be helpful to apply MTP to anxiety in a more deliberate manner. A multidimensional description of anxiety would show how worried thoughts, compulsive actions, and fearful feelings are sometimes related to anxiety. This description would also specify ways that biology, interpersonal patterns, social systems, and cultural contexts can shape the way that anxiety is experienced by a particular client. Conceptual models could be developed that describe anxiety from different theoretical perspectives. If MTP were being used to treat anxiety, counselors would be encouraged to engage in integrative treatment planning by conducting a multidimensional survey and formulating a multitheoretical

conceptualization. Key strategies could be identified that have been used to successfully treat anxiety as a part of evidence-based practice. For example, cognitive, behavioral, and systemic treatments for different types of anxiety have already been identified as "well-established" or "probably efficacious" (Chambless et al., 1998). Future research could investigate whether MTP for anxiety can be implemented effectively and outcomes can be compared to treatments based on only one theory.

MULTITHEORETICAL PSYCHOTHERAPY FOR SUBSTANCE ABUSE

Client's Presenting Concern

Dana is a Euro-American female in her mid-thirties. She is divorced and lives with a roommate. She was referred to psychotherapy through her workplace Employee Assistance Program after missing too much work. Dana's supervisor thinks she does good work for the company but that her frequent illnesses related to alcohol may interfere with her ability to be productive. Dana recently received her first arrest for driving while intoxicated although she reports that she has driven drunk dozens of times. Dana began using alcohol in her teens and has been a regular drinker ever since, with only a few short periods of abstinence. Alcohol was a problem in her marriage. Both Dana and her ex-husband would drink to excess and would get into arguments that sometimes became physical conflicts. Dana has been in a couple of serious relationships since her divorce but they usually have not lasted longer than six months.

At the time of her first session with Dr. P., Dana met DSM-IV criteria for Alcohol Dependence (Axis I: 303.90; American Psychiatric Association, 1994, p. 195). Most of Dana's social activities involve drinking alcohol with friends. She reported that she has embarrassed herself at work gatherings when she got intoxicated and behaved inappropriately. At times, she has been unable to go to work the day after an episode of binge drinking. When Dana has tried to quit drinking, she was unable to maintain her abstinence, and she often drinks more than she has intended. Dana reported experiencing physical symptoms of tolerance and withdrawal. She needs to drink more alcohol now to get the same effect compared to her drinking in the past. When Dana does not drink alcohol daily, she feels anxious and shaky and drinks more alcohol to relieve these withdrawal symptoms. Dana told Dr. P. that she did not think she needed to stop drinking completely but realized that alcohol was beginning to have negative consequences that she wanted to control.

Watching for Focus Markers

During the first session with Dana, Dr. P. noticed several focus markers related to actions, biology, and social systems. Related to Dana's actions, Dr. P.

observed compulsive behaviors and conditioned responses. For example, Dana had been unable to control her use of alcohol and used drinking as a response to both positive and negative stimuli in her environment. Related to biology, Dr. P. noted substance abuse, somatic complaints, and poor health habits. Dana reported physical symptoms related to alcohol abuse and had been missing work frequently because of illness and alcohol abuse. Listening to Dana describe her family, Dr. P. noticed social systems focus markers including unresolved family problems, inability to connect socially, systemic patterns in relationships, and distorted personal narratives. For example, Dana's drinking problems and failed relationships mirrored her alcoholic family and her parents' pattern of divorce.

Conducting a Multidimensional Survey

During the second session, Dr. P. and Dana discussed seven dimensions that might be related to her drinking problem. Here is a summary of the multidimensional survey:

- *Thoughts:* Dana reported a variety of thoughts that indicated some inconsistencies in how she thought about alcohol. On the one hand, she reported that "I don't want to be an alcoholic like my Dad" and "I shouldn't get drunk so often." On the other hand, she stated that "I should be able to control my drinking on my own" and "I really enjoy going out with my friends and partying."
- *Actions:* Dana reported that she wanted to decrease episodes of binge drinking that interfere with work. Dana said that she did not want to eliminate drinking but wanted to control her drinking. She said that she did not want to drive drunk anymore or engage in other dangerous activities while drinking. Dana indicated that she wanted to improve her job performance and decrease her absences from work.
- *Feelings:* Dana reported feeling some fear that she might become an alcoholic like her father, although she did not like thinking about this possibility because it seemed depressing and made her feel helpless. When she resolves to control her drinking and then gets drunk anyway and misses work, Dana experiences feelings of guilt and shame.
- *Biology:* Dana reported biological symptoms related to alcohol dependence, including tolerance and withdrawal. Dana was recently diagnosed with an ulcer, and the physician treating the gastro-intestinal problems suggested she stop drinking. Dana reported a family history of alcoholism; her father is a chronic alcoholic who has developed liver problems. Dana also reported cousins, uncles, and grandparents with drinking problems. Therefore, Dr. P. assumed that Dana had a genetic predisposition for alcoholism.

- *Interpersonal:* Dana reported a long-term pattern of failed romantic relationships. She was married and divorced once in her early twenties, and Dana reported that the relationship failed within a year of the wedding. Initially, Dana was not sure if her relationships had been negatively impacted by her drinking, but when queried, she could report times when alcohol caused relationship problems and fights. She also reported that a romantic break-up six months ago had resulted in increased drinking and more frequent problems with alcohol.
- *Social:* Dana told Dr. P. that her father was a life-long alcoholic and her mother was codependent. Her parents divorced when Dana was a teen. Dana's older brother worked in their father's car repair business and frequently helped Dad when he was too drunk to work. At about the time of her parents' divorce, Dana assumed a rebellious role in the family and began partying with friends and having sex with boys from her high school.
- *Cultural:* Dana grew up in a poor Euro-American family from a small town in the Southeast. Her home town was predominantly Euro-American and African American although Dana said these two social groups seldom mixed. Dana felt ashamed of her poor background and referred to members of her community as "hillbillies" and "rednecks." After high school graduation, Dana moved to a large metropolitan area and only visited her family on holidays.

Establishing an Interactive Focus

After discussing all seven dimensions, Dana said that she wanted to focus on her actions related to drinking and how this impacts her biological health. When they discussed contextual dimensions, they agreed to focus on Dana's family as a social system that impacts her actions. In order to monitor the interaction between actions, biology, and social systems, Dr. P. asked Dana to begin to keep track of how much she was drinking, the social context of her drinking (drinking with friends, drinking after a hard day at work, and so forth) and how her drinking impacts her biological health (such as vomiting, hangovers, and withdrawal symptoms). The "interaction worksheet" that Dana filled out for Dr. P. is illustrated in Figure 11.3. This worksheet allowed Dr. P. to identify a pattern in which Dana tried not to drink after a night of binge drinking but felt "jittery" and decided to drink to calm herself down. They also realized that Dana was frequently unable to meet her goal of moderate drinking and would often slide into unplanned excessive drinking. Dr. P. assumed that Dana's actions, biology, and social system were closely related. Obviously, Dana's use of alcohol resulted in physical symptoms, but the relationship between actions and biology was multidirectional. Dana's symptoms of

Day	Actions	Biology	Social
Monday	4 beers	Felt good, relaxed	Hanging out with Elaine after work.
Tuesday	6 beers	Headache	Home alone after argument at work.
Wednesday	Shared pitchers and shots of whiskey.	Felt sick at night. Hangover in morning.	Went out with friends to celebrate Tim's birthday.
Thursday	2 beers	Still felt bad from last night. Felt jittery at night and drank to calm self.	Stayed home alone. Didn't want to drink.
Friday	8 beers	Headache	Watching videos with Elaine.
Saturday	Pitchers and shots	Threw up. Slept late the next morning. Hangover.	Partying and dancing at the bar with a new guy I met.
Sunday	2 beers	Felt jittery at night so had a couple beers to calm down.	Didn't want to drink. Needed to get ready for project at work.

FIGURE 11.3 Dana's interaction worksheet allowed her to keep track of the interaction between actions, biology, and social systems.

tolerance indicated that her body had adapted to her regular use of alcohol. Her symptoms of withdrawal made it difficult for her to use less alcohol and resulted in increased drinking after short-lived attempts at abstinence. Dana's actions and biology were also shaped by current social systems and her family history. Most of her binge drinking occurred when socializing with friends. Her family of origin and the social role she played in her family both supported her drinking behaviors, and, biologically, her family history suggested a genetic predisposition for alcoholism.

Although Dr. P. and Dana agreed to focus on actions, biology, and social systems, Dr. P. also paid attention to interactions with other dimensions. Dr. P. was aware of the inconsistencies in Dana's thoughts about alcohol that led to ambivalent feelings about drinking. At times, alcohol seemed like Dana's best friend, and at other times it was her worst enemy. Drinking had taken a toll on Dana's interpersonal relationships, but since she was not in a romantic

relationship now, it was difficult for Dana to focus on interpersonal patterns. Because alcohol had played such a pivotal role in Dana's family system, it made more sense to look at formative relationships systemically rather than focusing on a single interpersonal relationship as the genesis of interpersonal struggles (as is more common in a psychodynamic-interpersonal conceptualization).

During the preliminary multidimensional survey, it was difficult for Dana to recognize and talk about her cultural background. As a Euro-American, it was hard for Dana to think about being a member of a specific culture. Dana could talk about the racial tension between whites and blacks in her home town, but it was easier to describe African American cultural values and behaviors. White culture was invisible to Dana, like the water in which a fish swims but never sees. When queried, Dana could describe her Southern, poor, rural, Euro-American culture but only in negative ways using derogatory terms like "white trash" and describing her community as filled with "rednecks." Dr. P. found it curious that Dana's cultural identity was shaded with negativity. The more she listened to Dana, however, the more convinced Dr. P. became that Dana's drinking behaviors had been shaped and were being supported by her cultural values and behaviors. Therefore, later in the course of psychotherapy, Dr. P. and Dana explored culture contexts as a focal dimension, although it had not been recognized in the initial sessions.

Formulating a Multitheoretical Conceptualization

Because Dr. P. and Dana agreed on an initial focus on the interaction between actions, biology, and social systems, Dr. P. formulated a multitheoretical conceptualization based on ideas from behavioral, biopsychosocial, and systemic-constructivist psychotherapy. Later, a focus on cultural contexts was added, and Dr. P. incorporated multicultural concepts into her formulation.

Behavioral Conceptualization

From an operant conditioning perspective, substance abuse can be seen as an action that has been reinforced directly by the effects of the abused drug and indirectly by the social environment (McCrady, 1993). Although substance abuse may also have negative consequences, these are often minimized or overlooked by people struggling with addictions. From a stimulus-response perspective, the desire to drink can be seen as a conditioned response to environmental stimuli such as stressful events. Many alcoholics have reported that drinking became a response associated with both positive and negative affective states (Sobell & Sobell, 1993); a way to celebrate good news and a way to sooth oneself after bad luck. When Dr. P. asked Dana about the role of drinking, Dana reported many positive reinforcers and associations. Dana liked the taste of beer and liquor, and enjoyed the way it made her feel. Dana usually drank when she socialized with friends—providing a strong association

between alcohol and social support. When Dr. P. explored negative consequences, Dana could identify negative physical consequences like vomiting and hangovers. With more prompting, she was also able to admit that she had lost jobs because of irregular attendance at work related to excessive drinking. Dana reported a recent arrest for drinking while intoxicated as well as increased problems at work. Dana was aware of these negative consequences and had tried to cut down on her use of alcohol but had been unsuccessful in changing her actions on her own. In trying to understand alcoholism from a behavioral perspective, it is important to recognize that decreased drinking is not likely to occur in the same way that other actions might change. Alcoholics must often acknowledge their "loss of control" rather than responding to "behavioral prescription designed to gain control" (Brown, 1985, p. 83). Therefore, a behavioral perspective alone is unlikely to be successful without understanding this action within a broader context.

Biopsychosocial Conceptualization

From a biopsychosocial perspective, alcohol abuse is understood as a biological addiction to a central nervous system depressant. Some researchers have described alcoholism as a disease that sometimes moves through progressive stages (e.g., Jellineck, 1960). Alcoholism runs in families and is assumed to have a strong genetic component although a cause-and-effect relationship is difficult to substantiate. Physiological conditions related to alcoholism have been investigated including, "the production of morphine-like substance in the brain . . . , abnormalities in sugar metabolism, food allergies, and endocrine abnormalities" (Lawson & Lawson, 1998). Because there is not a conclusive biological explanation, it is important to consider the interaction of genetic and environmental effects. Because alcohol abuse can have a serious impact on physical health, it is also important to monitor direct physical effects like blackouts and withdrawal symptoms as well as problems that develop over a longer period of time such as liver and gastrointestinal problems.

When Dr. P. asked her about biological symptoms, Dana reported increased drinking to get the same effect (tolerance) and feeling anxious and shaky when she tried not to use alcohol (withdrawal). Dana had been diagnosed with an ulcer and told that her use of alcohol was exacerbating her gastrointestinal problems. Dr. P. wanted to help Dana understand the biological causes of her drinking problem as well as the biological problems that were resulting. Dr. P. assumed that any changes in Dana's drinking would need to occur within the broader context of a movement toward greater physical wellness.

Systemic-Constructivist Conceptualization

From a systemic point of view, it is important to understand the way substance abuse may have its roots in an individual's family of origin. Addictions often run in families, and there seem to be both genetic and environmental

components. Dana reported to Dr. P. that her father was a long-term alcoholic and that her father's drinking problem had been an important contributor to her parent's divorce. People who have studied alcoholic families have observed that children of alcoholics often develop rigid roles or coping styles. Claudia Black (1982) described four family roles called the *responsible one,* the *adjuster,* the *placater,* and the *acting out child.* When Dana described her family structure to Dr. P., it sounded as though Dana had played the role of the acting out child and her older brother had been the responsible one. As a teenager, Dana reacted to her parent's divorce by drinking alcohol and getting involved in casual sex. From a systemic perspective, "acting out children will cause disruption in their own lives and in the lives of other family members. In doing so, they will often provide distraction from the issue of alcoholism" (Black, 1981, p. 26). Because Dana was not getting the positive support she needed from her family, she drew negative attention to herself by engaging in destructive and disruptive actions. Dr. P. noted the irony that Dana's drinking had begun as a rebellion from her alcoholic family.

Multicultural Conceptualization

Although it was easy for Dr. P. to recognize the family context of Dana's alcohol problem, over time it became clear that there was a broader cultural component as well. Dana grew up in a small town in a rural area in which alcohol played an important social role. Her hometown was close to a famous distillery, and the whiskey produced there was a source of regional pride and identity. During Prohibition, the area had been full of "moonshiners" who provided the state with contraband liquor. Dana said that drinking beer and liquor was a part of almost every social event she can remember growing up. Starting in junior high school, she and her friends would drink together, and the drinking only got more frequent and intense in high school. When she moved to a large city, she made friends at a local bar that played country music, and this setting provided some cultural continuity to her rural upbringing in the midst of a new urban setting. Dana would usually hang out at bars every weekend and sometimes stop after work for happy hour. She met most of her boyfriends at bars, and drinking with friends and coworkers was a mainstay of her social life. Dana and her friends equated drinking with having a good time and saw people who did not drink as uptight people who didn't know how to have fun. Dr. P. realized that part of helping Dana change her drinking habits would involve understanding the cultural role that drinking played and to help her identify new cultural roles. Dr. P. hoped that she would be able to help Dana identify positive parts of her cultural identity rather than seeing herself as a hillbilly or a redneck.

Dr. P. used these four conceptualization models in an integrated way and saw Dana's family system and cultural context as shaping her drinking

behavior that was negatively impacting her physical health. Dana's actions were impacting her health, but her physical symptoms of alcohol dependence were also making it harder for her to change her behavior. Socially, alcohol use had been modeled by her father, and drinking had been a way for Dana to escape from her family during troubled times. Drinking was an important part of Dana's social support network and her cultural identity. Dr. P. knew that she would need to use these complementary perspectives in order to understand Dana and to help her change her drinking pattern.

Choosing Interventions from a Catalog of Key Strategies

In her work with Dana, Dr. P. emphasized the use of behavioral, biopsychosocial, systemic-constructivist, and multicultural-feminist strategies in order to change her actions and improve her health, based on understanding the social and cultural contexts that shaped Dana's use of alcohol.

Behavioral Strategies

Dr. P. used several different behavioral skills to identify Dana's actions and to understand their impact. Some of the behavioral strategies that were used included clarifying the impact of actions, identifying target actions, encouraging active choices, establishing schedules of reinforcement, and constructing a hierarchy. For example, in order to encourage active choices, Dr. P. asked Dana to set specific goals about her drinking rather than relying on vague intentions. By being more specific about Dana's behavior, Dr. P. was able to help her evaluate her drinking habits and to be more realistic about whether controlled drinking was a realistic goal that would resolve her problems. After Dana was unable to control her drinking as she had originally hoped, she revised her goal with Dr. P.'s help and concluded she needed to abstain from alcohol and needed to seek social support from Alcoholics Anonymous. Although Dana experienced some relapses, she realized that abstinence was a more appropriate behavioral goal for her than controlled drinking. Chapter Five described the way Dr. P. used behavioral strategies to help Dana measure and change her actions.

Biopsychosocial Strategies

Dr. P. used biopsychosocial strategies to help Dana understand how alcohol was related to her overall health and how her mind and body interacted to impact her drinking. Some of the biopsychosocial skills that Dr. P. used with Dana included recognizing the influence of psychological functioning on health, understanding health within a sociocultural context, reducing substance use, fostering physiological awareness, and facilitating acceptance of illness. For example, Dr. P. helped Dana recognize and admit that she was an alcoholic and to set a goal of abstinence. As a result of these biopsychosocial

interventions, Dana was able to understand her drinking as one of many interrelated factors that impact her physical wellness. In order to change her use of alcohol, it was helpful for Dana to make a larger commitment to improving her health. Dr. P. was able to use these biopsychosocial strategies to help Dana understand how her mind and body interact and how alcohol might be threatening both her physical and emotional well-being. Chapter Seven described the use of biopsychosocial strategies in greater detail by demonstrating the way Dr. P. implemented health-oriented skills with Dana.

Systemic-Constructivist Strategies

Dr. P. used systemic-constructivist strategies to help Dana understand how her current drinking problem had been shaped by her family of origin as well as by current social systems like her work setting and her network of friends. Some of the systemic strategies Dr. P. used included viewing families as systems, describing family structure, and searching for multigenerational patterns. For example, Dr. P. helped Dana recognize the way that the family had changed at the time of her parents divorce in a way that left her disconnected and isolated. Constructivist strategies included externalizing problems, utilizing clients' resources, and orienting toward the future. For example, in order to externalize her drinking problem, it was helpful for Dana to shift from thinking of herself as a drunk to thinking about alcoholism as something outside herself with which she was fighting. As a result of these systemic and constructivist strategies, Dana was able to understand the social origin of her drinking problem and how she could change her personal story by seeing herself in a new way rather than passively accepting the social role that had been painted for her by her family. Chapter Nine described the way Dr. P. used systemic-constructivist strategies to help Dana understand her drinking problem within its social context as well as how it shaped her personal narrative.

Multicultural-Feminist Strategies

Dr. P. used multicultural strategies to help Dana understand her alcohol problem within a broader cultural context that extended beyond her family and shaped her cultural identity. Some of the multicultural strategies that Dr. P. used included viewing Dana culturally, creating a culturally-appropriate relationship, illuminating similarities and differences, and facilitating identity development. For example, it was helpful to encourage Dana to embrace parts of her culture from which she had distanced herself and to find positive ways to express her identity. A clear understanding of how her culture had influenced her substance abuse problem allowed Dr. P. to make more appropriate interventions that were attuned to Dana's worldview. Chapter Ten provided examples of how Dr. P. used multicultural strategies to address Dana's problem with alcohol.

Although the strategies that Dr. P. used from different theoretical approaches were described in different chapters, these interventions were used in an integrated manner throughout the course of psychotherapy. Systemic-constructivist and multicultural-feminist strategies were used as part of an ongoing effort to understand Dana's social and cultural environment. These strategies were integrated with behavioral and biopsychosocial strategies designed to change Dana's actions and improve her physical health. By focusing on both contextual dimensions and concurrent functioning simultaneously, Dr. P. was able to choose intervention strategies that fit Dana's social and cultural context. Dr. P. was committed to looking at the interaction between each of these dimensions and to combine theoretical approaches in order to maximize the chance of helping Dana achieve her goals.

Outcome

With Dr. P.'s help, Dana was able to stop abusing alcohol. This represented an important change in Dana's actions that would benefit her biological health. However, Dr. P. believed she was better able to help Dana make behavioral and biological changes by understanding the role alcohol played in Dana's family and in her culture. By exploring her family system and her cultural experiences and values, Dr. P. was able to make more appropriate interventions that supported new actions and health practices. In addition to individual psychotherapy, Dr. P. had encouraged Dana to gain social support through Alcoholics Anonymous and to work through a twelve-step program of recovery. AA helped Dana modify her social and cultural outlook in a way that was difficult to achieve through individual psychotherapy alone.

Future Development of MTP for Substance Abuse

In this case example, Dr. P. used a multitheoretical approach to treat Dana's substance abuse. The future development of this approach may include a more technical description of MTP for substance abuse. A multidimensional description of substance abuse would describe the thoughts, actions, and feelings that are often associated with substance abuse. This description would also describe how biology, interpersonal patterns, social systems, and cultural contexts are related to problems with alcohol and other drugs. Multitheoretical conceptualization would be facilitated by describing substance abuse from different theoretical perspectives. Key strategies could be drawn from empirically supported treatments for substance abuse. For example, cognitive, behavioral, psychodynamic, and systemic treatments for different types of chemical abuse and dependence have already been identified as "probably efficacious" (Chambless et al., 1998). Future research could investigate whether psychotherapists can effectively implement MTP for substance abuse and outcomes can be compared to established treatments.

MULTITHEORETICAL PSYCHOTHERAPY FOR HEALTH BEHAVIORS

Client's Presenting Concern

Abraham is an African American man in his mid-forties. He is married with two children. He works as an attorney and is a self-described "workaholic" who recently had his first heart attack. His cardiologist had referred Abe to Dr. P. because Abe had not been able to change his health behaviors for several years after having been diagnosed with high blood pressure. This medical crisis served as a wake-up call for Abe who now wants to make changes in his work and family life. Abe was referred to Dr. P. for psychotherapy to help him understand and change some of the work habits that threaten his physical and emotional health. Abe told Dr. P. that he needed help in making changes in his work life and health behaviors in order to improve his physical health and to preserve his relationship with his wife and children. On the outside, Abe appeared successful, but he told Dr. P. that he feels trapped on the inside and doesn't know how to get off the "treadmill" that he seems to be riding.

At the time he met with Dr. P. for the first time, Abe met the DSM-IV criteria for two different Psychological Factors Affecting a Medical Condition (Axis I: 316, American Psychiatric Association, 1994, p. 678; Axis III: 402.91, American Psychiatric Association, 1994, p. 816). First, Abe displayed Maladaptive Health Behaviors Affecting Hypertensive Heart Disease with Congestive Heart Failure. The health behaviors associated with his high blood pressure and heart attack included stress, overworking, overeating, and lack of exercise. Second, Abe also displayed Personality Traits or Coping Style Affecting Hypertensive Heart Disease with Congestive Heart Failure (Axis I: 316, American Psychiatric Association 1994, p. 678; Axis III: 402.91, American Psychiatric Association 1994, p. 816). The personality traits associated with his hypertension included pressured behavior contributing to cardiovascular disease. Abe did not meet diagnostic criteria for Obsessive-Compulsive Personality Disorder, although he was "excessively devoted to work and productivity to the exclusion of leisure activities and friendships" (American Psychiatric Association, 1994, p. 672). In addressing health concerns in psychotherapy, Dr. P. saw her role as focusing on psychological factors like thoughts, actions, feelings, and interpersonal patterns that may be contributing to Abe's health problems.

Watching for Focus Markers

The first time Dr. P. met with Abe, she observed focus markers related to thoughts, biology, interpersonal patterns, and cultural contexts. Markers for focusing on thoughts included inaccurate thoughts and pervasive worries. For example, Abe reported frequently worrying that he was not working hard enough to accomplish his goals despite regularly working ten to twelve hours

a day, six or seven days a week. Dr. P. observed markers for a biological focus including physical illness and lack of physical awareness. Abe's heart attack at an early age was an obvious sign that Abe's physical health was threatened. Beyond this obvious marker, Abe reported that he did not feel in touch with his body; that he was living in his body but that it was not his own. Interpersonal focus markers included repetitive interpersonal patterns and distorted interpersonal relationships. Abe's obsessive thoughts about work seemed to be related to his father who taught him to work hard and take advantage of every opportunity that came his way. His preoccupation with work was causing problems in his relationship with his wife and children. Finally, markers for a cultural focus included confusion about cultural identity and experiences of discrimination. Abe had tried to distance himself from the African American community and tried to fit into Euro-American culture. As a result, he felt as though he did not fit in with either group.

Conducting a Multidimensional Survey

Dr. P. conducted a multidimensional survey during her second session with Abe. Here is a summary:

- *Thoughts:* Abe's thoughts drive him toward working too hard. Abe reported thinking thoughts like "I need to work harder to accomplish my goals" and, "If I slow down, I might fail." Abe knew he was neglecting his health and his family but was unable to shift his thoughts in that direction.
- *Actions:* Abe described working every day and never taking time off for relaxation or recreation. He told Dr. P. that he spends too much time at work and not enough time with his wife and children.
- *Feelings:* Abe often feels anxious and afraid that he may not fulfill his potential. Now, after being diagnosed with high blood pressure and suffering a heart attack, he is also afraid of dying at an early age because he is not taking care of his health.
- *Biology:* Abe has been warned by doctors that if he does not improve his physical health and lower his blood pressure that he is at risk for another heart attack. He knows that he has to make serious changes in his lifestyle in order to preserve his health. In the past, Abe has tended to ignore his physical body and to press on in spite of any signs of physical weakness or stress.
- *Interpersonal Pattern:* At work, Abe reported that he wants to be respected and admired by his colleagues, especially a senior partner in the law firm who had served as Abe's mentor. Sometimes, he thinks he is not doing well enough and feels compelled to work even harder. At home, he feels withdrawn from his family, and his wife thinks that he is

not "pulling his weight" around the home. Abe has some awareness that his life has been shaped by his proud and hard-driving father who always pushed him to accomplish more.

- *Social Systems:* In his family of origin, Abe played the role of a "hero" and was seen as the brightest of his siblings and the one who might bring recognition to the family. Abe always wanted to make his parents proud and learned to suppress his own desires for the sake of the family. In his current family, Abe plays the breadwinner role but is not as active in parenting his children as he would like to be.
- *Culture:* As an African American, Abe watched his father work hard in a blue-collar job despite being intellectually gifted. Abe was told that he had a chance to rise above discrimination and prove himself and to set an example for other blacks. However, as an attorney working for a predominantly white law firm, Abe felt he had to fit in with the dominant Euro-American culture.

Establishing an Interactive Focus

After Dr. P and Abe discussed these seven dimensions, an initial focus on biology and thoughts was agreed upon. Dr. P and Abe decided to begin to look at the thoughts that seemed to fuel his compulsive work habits that threaten his biological health. The goal was to help him think about his health, job, and family in more adaptive ways that would support healthy habits and improve his physical well-being. In order to start looking at these two dimensions, Dr. P asked Abe to observe and record the thoughts that influenced his health habits. Dr. P asked Abe to write down health-related thoughts that came to his mind throughout the week such as "I don't have time to exercise." This homework assignment was designed to help Abe discover the way that different dimensions of his life interact with one another.

After a few sessions focusing on the interaction between thoughts and biology, Dr. P. came to the conclusion that Abe's health-related thoughts were closely related to his relationship with his father and were deeply imbedded in his cultural experiences as an African American. Dr. P. talked to Abe about the importance of these dimensions, and they agreed to expand the focus to include interpersonal patterns and cultural contexts. Abe agreed with Dr. P. that the current situation was related to an interpersonal pattern that originated with his father. Abe had always looked up to his father who told him that he would have more opportunities for success. Abe had always experienced a compulsive drive to succeed and make his father proud. Abe also agreed to explore his African American culture and the way he felt fortunate to have succeeded where others had failed but also felt that he could never make a mistake because he might fail as a role model for other blacks. It

appeared to Dr. P. that all four focal dimensions were highly interactive. Interpersonal patterns and cultural contexts had fostered obsessive thoughts about work that supported a pattern that threatened Abe's biological health.

Formulating a Multitheoretical Conceptualization

As Dr. P. got to know Abe better, she began to formulate a conceptualization related to each of these focal dimensions. In order to describe the role of thoughts, biology, interpersonal patterns, and cultural contexts, Dr. P. used cognitive, biopsychosocial, psychodynamic-interpersonal, and multicultural models of conceptualization.

Biopsychosocial Conceptualization

From a biopsychosocial perspective, biology interacts with both psychological factors (like thoughts, actions, and feelings) and social dimensions (like interpersonal patterns, social systems, and cultural contexts). It is assumed that these interactions are multidirectional. In formulating a biopsychosocial conceptualization for Abe, Dr. P. looked first at the way his psychological functioning was impacting his health. Psychological factors that contributed to his high blood pressure and heart attack might include thoughts like "I need to work harder"; actions that included long hours of work, poor eating habits, and minimal exercise; and feelings like anxiety and fear of failure. Conversely, Dr. P. also hypothesized about ways his health was impacting his psychological functioning. For example, his health problems were resulting in thoughts like "I might die at an early age," a desire to change behavioral patterns, and feelings like fear of dying and anger at himself for letting his health diminish. Social factors that contributed to his health problems included pressure to succeed from his parents and a cultural expectation that he should work hard to set an example for other African Americans. On the other hand, his health problems were having a negative impact on his family system by causing stress and worries for his wife and children. His wife wanted him to take better care of his health, but this conflicted with an internalized role as breadwinner that pressed him to work long hours. His inability to change his health habits in the past was a source of ongoing conflict between Abe and his wife. Dr. P. was aware of all of these interactions as she thought about Abe's concerns from a biopsychosocial perspective. At the core of this conceptualization was Dr. P.'s perception that his obsessive thoughts and compulsive work habits were leading to stress that contributed to his health problems.

Cognitive Conceptualization

In formulating a cognitive conceptualization, Dr. P. looked at how Abe's thoughts impacted his feelings and actions. Abe reported frequent thoughts like "I need to work late tonight to make sure I'm ready for the meeting tomorrow." These thoughts resulted in feelings of anxiety and fear of failure.

The resulting action was staying at work for long hours and spending less time at home with his family. Over time, Dr. P. also explored deeper beliefs that might result in automatic thoughts like "I need to work again this weekend." Dr. P. was aware that many core beliefs revolve around a theme of being helpless or being unlovable (J.S. Beck, 1995). Abe's core beliefs seemed to fit in the unlovable category and suggested that love was equated with the kind of respect that could be earned through hard work. Dr. P. hypothesized that one of the core beliefs that might be operating for Abe is a belief that he is not worthy of respect. An intermediate belief that Abe may have adopted in order to cope with thinking of himself as unworthy or unlovable is that "If I work really hard, maybe I can prove to others that I am worthy of respect." These core and intermediate beliefs may have fueled the automatic thoughts that resulted in overwork and threatened Abe's health.

Psychodynamic-Interpersonal Conceptualization

In order to formulate a psychodynamic conceptualization, Dr. P. listened closely to the way Abe described his interactions with important people in his life. She pieced together these *relationship episodes* to identify a *core conflictual relationship theme* (Luborsky, 1984; Book, 1998). After listening to several interpersonal episodes, Dr. P. noticed a common theme in which Abe hoped for recognition or respect but, instead of receiving recognition, Abe felt that others were disappointed in his efforts. In response to this perceived disappointment, Abe felt guilty and would try harder to win the recognition that he craved. As Dr. P. explored this interpersonal pattern, it seemed to have been learned in his family of origin and, particularly, in his relationship with his father. Dr. P. hypothesized that Abe's relationship with his father had been internalized in a way that shaped current interpersonal perceptions that resulted in compulsive work habits.

Multicultural Conceptualization

In order to formulate a multicultural conceptualization, Dr. P. listened for cultural messages that Abe had learned that might be related to his presenting concern. One of the most obvious cultural messages that Abe had learned as an African American was that he should work hard to fulfill his potential and serve as a role model for other blacks. Dr. P. also listened for identity development experiences. She noticed that being academically gifted had isolated Abe from environmental barriers but had exposed Abe to more subtle forms of racism like tokenism. In order to succeed in mainstream America, Abe had played down his African American identity and distanced himself from his community. Unfortunately, he did not feel this actually helped him fit into Euro-American society, and as a result he felt marginalized and isolated from both groups. Dr. P. wondered if exploring his identity as an African American and developing more affinity with his culture might be helpful for Abe in his search to find himself.

Dr. P. also hoped that Abe might find different ways to serve as a cultural role model that might not threaten his health. Dr. P. wanted to help Abe make informed choices about the cultural messages he chose to embrace or revise.

Dr. P. viewed all four of these conceptualizations as complementary. She believed that Abe's cultural and interpersonal experiences had resulted in thoughts that resulted in poor health practices. Dr. P. believed that it was important for her to understand Abe's thoughts and health practices in their interpersonal and cultural contexts in order to intervene in a way that fit Abe's personal worldview. Rather than basing her interventions on only one conceptual model, Dr. P. thought Abe would benefit from her use of multiple theoretical perspectives to support the integration of interventions from different approaches to psychotherapy. After working together for several weeks, Dr. P. and Abe drew a diagram that illustrated the way that cultural values and interpersonal patterns shaped the interaction between thoughts and biology. This visual representation allowed both of them to see more clearly the way that the current situation had been shaped by cultural and interpersonal contexts. This interaction diagram is illustrated in Figure 11.4.

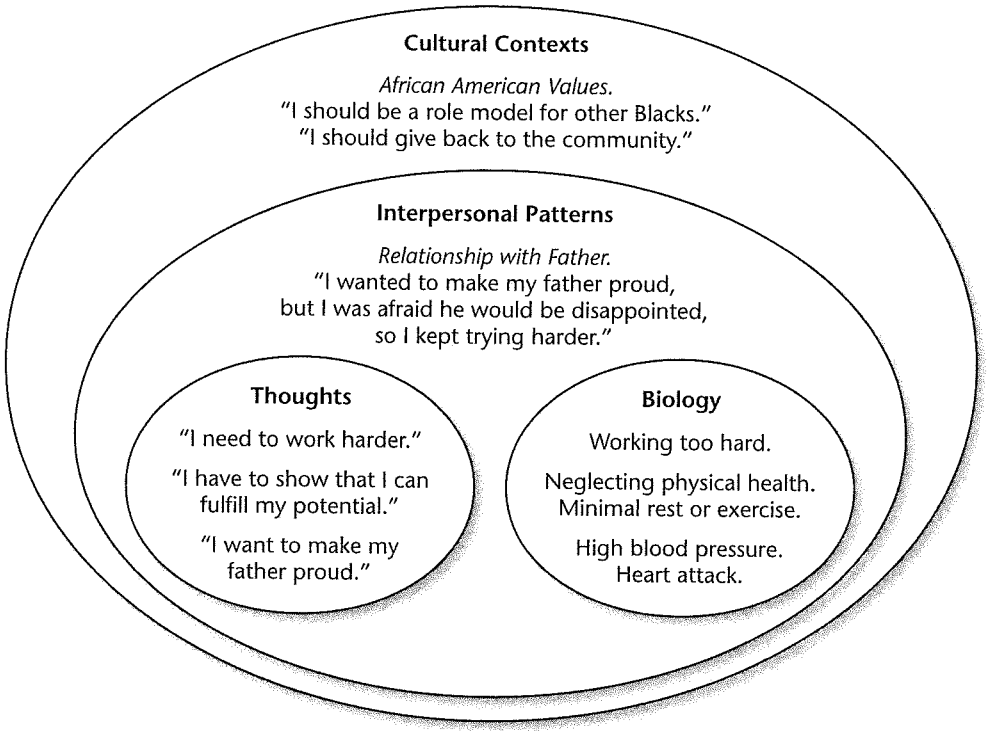


FIGURE 11.4 Abe's interaction diagram highlighted the way that cultural and interpersonal contexts impacted his thoughts and biological health.

Choosing Intervention from a Catalog of Key Strategies

The intervention strategies that Dr. P. chose to emphasize corresponded to the focal dimensions that were chosen. Therefore, Dr. P. used a variety of cognitive, biopsychosocial, psychodynamic-interpersonal, and multicultural-feminist strategies.

Cognitive Strategies

Dr. P. used cognitive strategies to help identify his dysfunctional thoughts that were negatively impacting his health and relationships. Some of the cognitive strategies that Dr. P. used with Abe included clarifying the impact of thoughts, illuminating core beliefs, testing hypotheses, and reinforcing adaptive cognitions. For example, Dr. P. was able to reinforce Abe's adaptive belief that he doesn't have to work every day by finding satisfying ways to enact this cognition. As a result of looking closely at his thoughts and beliefs, Abe was able to revise his conclusions and find ways of perceiving his situation that would result in better health practices and more satisfying relationships. Chapter Four described the way Dr. P. used cognitive strategies to help Abe change his thoughts.

Biopsychosocial Strategies

Dr. P. used biopsychosocial strategies to help Abe make changes in health practices that would help him live a longer and healthier life. Some of the biopsychosocial strategies that Dr. P. used with Abe included exploring the effect of biology on psychological functioning, considering the interaction between health and relationships, encouraging physical wellness, and teaching relaxation. For example, Dr. P. worked with Abe to identify an exercise routine that he felt comfortable initiating to support his health. As a result of adopting more adaptive health practices, Abe was able to lower his blood pressure and the risk of another heart attack. Examples of the biopsychosocial strategies used to help Abe gain control over his physical health and the way it interacts with his psychological and social well-being were described in Chapter Seven.

Psychodynamic-Interpersonal Strategies

Dr. P. used psychodynamic and interpersonal strategies to help Abe become aware of the interpersonal origin of some of his maladaptive thoughts and actions. Some of the psychodynamic strategies that Dr. P. used with Abe included identifying relationship themes, working through past conflicts, observing the therapeutic relationship, and resolving conflicts in the therapeutic relationship. For example, Dr. P. was able to help Abe recognize a longstanding pattern in which he hoped for recognition but feared disapproval from others. Dr. P. was able to share some of her own experiences in which she felt Abe's fear of disapproval impacted how she responded to him. The opportunity for interpersonal feedback within the therapeutic relationship was an important

source of insight for Abe that prepared him to make changes in the way he related to others. Chapter Eight described the way Dr. P. used psychodynamic-interpersonal strategies to help Abe become aware of interpersonal perceptions and to change relational interactions.

Multicultural-Feminist Strategies

Dr. P. used multicultural strategies to help Abe become aware of cultural experiences and messages he had internalized and to make conscious choices about enacting or revising his own worldview. Some of the multicultural strategies that Dr. P. used with Abe included clarifying the impact of culture, recognizing the impact of identity, appreciating multiple identities, exploring societal expectations, and integrating spiritual awareness. For example, Dr. P. explored the role of religion in Abe's life and helped him decide to begin attending church with his family again after several years' absence. As a result of Dr. P.'s use of multicultural strategies, Abe became more aware of how his cultural experiences had shaped him, and he was able to make more informed and integrated choices about how to enact his cultural worldview in a way that supported psychological adaptation. Examples of the multicultural strategies that Dr. P. used with Abe were described in Chapter Ten.

Although Dr. P.'s use of cognitive, biopsychosocial, psychodynamic-interpersonal, and multicultural-feminist strategies were highlighted in different chapters, these strategies were used concurrently and interactively. Dr. P. used psychodynamic and multicultural strategies to understand the origin of dysfunctional thinking that threatened Abe's biological health. In order to achieve holistic goals, Dr. P. combined different strategies to encourage multidimensional change.

Outcome

As a result of psychotherapy with Dr. P., Abe was able to make important changes in the way his thoughts impact his biological health within the context of his interpersonal and cultural environment. Abe adopted more adaptive beliefs about work that allowed him to change his health habits. By understanding the interpersonal and cultural origins of his beliefs, he was able to make informed choices about what changes he wanted to make. As a result, he was able to improve interpersonal relationships with family and friends and to find ways to express his cultural identity in new ways. All of this resulted in a healthier lifestyle that allowed Abe to lower his blood pressure and decrease his risk of another heart attack.

Future Development of MTP for Health Behaviors

Dr. P. treated Abe's health problems using a multitheoretical approach in this case example. In the future, it may be helpful to describe MTP for health

behaviors in a more deliberate manner. A multidimensional description would explain the thoughts, actions, and feelings that are often associated with health problems, as well as describing how biology, interpersonal patterns, social systems, and cultural contexts are related to health. Counselors would be encouraged to formulate multitheoretical conceptualizations using different theoretical models that describe health using complementary perspectives. Key strategies could be drawn from evidence-based practice in *Health Psychology*. For example, behavioral, cognitive, biopsychosocial, and interpersonal treatments for different types of health problems have already been identified as "well-established" or "probably efficacious" (Chambless et al., 1998). In the future, research could explore the implementation of MTP for health problems and compare outcomes to treatments based on single-theory approaches.

CHAPTER SUMMARY

This chapter applied integrative treatment planning to four different clients with presenting concerns related to depression, anxiety, substance abuse, and health. With all four clients, Dr. P. worked as an integrative psychotherapist and combined strategies in different ways for each client, based on a multidimensional survey and a multitheoretical conceptualization. The first case example demonstrated MTP for depression with Claire, who felt hopeless and depressed after her mother's death. Dr. P. and Claire agreed to focus on the interaction between her thoughts, feelings, and interpersonal patterns. Dr. P. used cognitive, experiential-humanistic, and psychodynamic-interpersonal strategies to encourage healthy grief and recovery. As a result of psychotherapy, Claire was able to think in a new way, recognizing that she could go on in a different way without her mother. Instead of feeling overwhelmed by hopelessness and despair, she was able to express adaptive feelings of sadness and grief. Claire was also able to understand the interpersonal pattern that had made it hard for her to let go of the favored role in her mother's life.

Second, MTP for anxiety was described for Ben, who was anxious because he was hiding his gay sexual orientation from his family. Feelings, actions, and social systems were identified as focal dimensions. Dr. P. integrated experiential, behavioral, and systemic approaches in order to encourage change based on awareness and a clear understanding of his family system. As a result of psychotherapy, Ben reported less anxiety and was able to process other feelings about his family. He decreased avoidant behaviors in the family and was able to seek social support from his sister and from a spiritual community. Ben began to understand the way his role in his family had shaped his development and became more comfortable expressing himself in ways that his family might not understand.

The third case example described MTP for substance abuse with Dana, a divorced woman who grew up in an alcoholic family. Dr. P. and Dana agreed to focus on the interaction between actions, biology, social systems, and cultural contexts. Dr. P. used a combination of behavioral, biopsychosocial, systemic-constructivist, and multicultural-feminist interventions in order to promote healthy change based on awareness of the role alcohol played in Dana's family and in the community in which she was raised. Outcomes included deciding not to use alcohol, attendance at AA meetings, and an increase in health-related behaviors, based on an understanding of her family of origin and cultural identity.

Fourth, MTP for health behaviors was demonstrated for Abe, a hard-working attorney who suffered a heart attack in his mid-forties. Focal dimensions included thoughts, biology, interpersonal patterns, and cultural contexts. Working with Abe to help improve his health, Dr. P. used an integrative approach that included cognitive, biopsychosocial, psychodynamic-interpersonal, and multicultural-feminist skills to encourage physical wellness by modifying beliefs that represented internalized interpersonal and cultural values. As a result of psychotherapy, Abe reported more balanced thinking about work, improved health, and more consistent commitment to his family. In order to make these changes, it was helpful for Abe to work through thoughts and feelings about his father with an awareness of the way his African American culture shaped this formative relationship and his own internalized values.